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GROUNDING OF THE M/V NEW CARISSA, LLOYDS NO. L8716136, OFF COOS BAY, OREGON, ON 04 FEBRUARY 1999, WITH MAJOR POLLUTION, NO INJURIES OR LOSS OF LIFE

ACTION BY THE COMMANDANT

The report of the Investigating Officer and forwarding comments of the Commanding Officer, Marine Safety Office Portland, Oregon and the Commander, Thirteenth Coast Guard District, have been reviewed. The report is approved subject to the following comments.

CAUSE OF THE CASUALTY

We concur that the cause of the grounding of the M/V NEW CARISSA was the Master's failure to make proper allowances for the effects of weather and sea conditions. Unfortunately, because the Master refused to testify during the investigation, there is little insight into his decisions during the chain of events that led to the grounding. It is impossible to discern whether or to what degree the Master considered courses of action other than weighing the anchor when he was notified that the anchor was dragging. For example, veering or letting out additional anchor chain, dropping the starboard anchor, maneuvering ahead while dragging the port anchor, or slipping or disconnecting the port anchor and chain and moving the vessel further out to sea may have prevented the grounding if executed in a timely manner. It is not apparent why the Master ordered the rudder hard to starboard while maneuvering ahead on the engines during the recovery of the port anchor. This action brought the vessel broadside to the wind and seas and eventually into a position from which it could not recover.

Additionally, the investigation revealed a lack of proper bridge resource management techniques, ineffective communications with the Coos Bay pilots, poor watchstanding procedures, and a lack of situational awareness on the part of the Master and Deck Officers. Had the Deck Officers worked more effectively as a bridge team to consider the situation as a whole and to discuss with the Master the decision to anchor and the anchoring technique to be used, the Master may have chosen a more appropriate course of action. The pilot was unaware of the Master's intention to anchor upon arrival and assumed that the vessel would stay at sea due to the prevailing heavy weather conditions. Had the Master requested advice from the pilot or had it been mentioned during the course of normal communications that anchoring under the forecasted conditions was not recommended, the Master may have elected to remain underway.

The M/V NEW CARISSA was apparently dragging anchor well before it came to the attention of the Master and Deck Officers. Had the Deck Officers properly maintained the anchor watch and effectively monitored the vessel's position, they would have recognized sooner that the vessel was dragging anchor and could have provided the Master with a more timely notification which, in turn, would have given him more time to assess the situation and to decide on the most appropriate course of action.

COMMENTS ON CONCLUSIONS

Conclusion 2: There is evidence of negligence on the part of the Master of the NEW CARISSA in deciding to anchor off Coos Bay, Oregon. The decision not to remain underway ultimately resulted in the vessel going aground.

Comment: We partially concur with this conclusion. While the Master's decision to anchor the M/V NEW CARISSA and the manner in which he did so initiated the chain of events that led to the casualty, given this anchorage with good holding characteristics as indicated by the U.S. Coast Pilot, Number 7 and absent any other advice to not anchor, other mariners may also have chosen to anchor their vessels. However, it is likely that they would have employed better anchoring techniques, such as veering or letting out more chain or setting both anchors.

Conclusion 7: Once the NEW CARISSA began to drag anchor, the Master's decision to weigh anchor and get underway was prudent.

Comment: We partially concur with this conclusion. Because the Master refused to testify, it is difficult to determine whether the Master's decision to the weigh anchor was the best course of action. Faced with a dragging anchor, a prudent mariner may have taken other actions to secure the safety of the vessel, such as veering or letting out additional anchor chain, dropping the starboard anchor, maneuvering ahead while dragging the port anchor, or slipping or disconnecting the port anchor and chain and moving the vessel further out to sea.

Conclusion 11: There is no evidence that the NEW CARISSA went aground as a result of a criminal act having been committed.

Comment: We concur with this conclusion and the amplifying comments of the Commander, Thirteenth Coast Guard District. The Coast Guard and the Department of Justice are currently exploring means to better coordinate and cooperate in the investigation of casualties causing harm to the environment and in the prosecution of environmental crimes.

ACTION ON RECOMMENDATIONS

Recommendation 1: That the National Oceanographic and Atmospheric Administration place a written warning in the U.S. Coast Pilot, Number 7, and pertinent National Ocean Survey Charts reflecting that the coastline of Coos Bay, Oregon is not a safe place to anchor during the winter months because of the rapid and severe onset of weather. The Coos Bay Pilots should meet with the Coast Guard and local maritime interests to develop the locations, weather conditions, and timeframe for this warning.

Action: We concur with this recommendation and the amplifying comments of the Commander, Thirteenth Coast Guard District. The development of safe anchorages requires coordinated local actions to address local conditions. As an important marine casualty and pollution prevention activity, the Coast Guard reviews practices for exposed anchorages in cooperation with local, state, and federal agencies and harbor safety committees where they exist. A copy of this report will be provided to each Coast Guard Captain of the Port to reinvigorate those efforts where necessary. A copy of this report will be provided to the National Oceanographic and Atmospheric Administration and the Coos Bay Pilot Association for use in developing an appropriate warning for the U.S. Coast Pilot, Number 7.

Recommendation 2: That all vessels, including bulk vessels, be required to have voyage data recorders that ensure course, speed, vessel rolling, wind speed and direction, water depth, rudder movements, engine direction and RPMs, and vessel position are captured. Conflicting testimony, the need to protect individual's Fifth Amendment rights, and the inability of witnesses to remember facts hinder investigations and thus preventative actions.

Action: We partially concur with this recommendation. Efforts are underway at the International Maritime Organization to establish requirements for voyage data recorders for vessels on international voyages. Under the current proposal, voyage data recorders would not be required on cargo vessels of less than 3,000 gross tons.

Recommendation 3: That the Coast Guard work with the maritime industry to develop safety guidelines to address the common practice of raising cargo hatches on bulk vessels prior to mooring.

Action: We partially concur with this recommendation. While the report does not state that the raising of the cargo hatches was a contributing factor to the casualty, it is not a good marine practice to open cargo hatches while at anchor during heavy weather conditions. We will develop and widely disseminate lessons learned from this casualty regarding this issue.

Recommendation 4: That the State of Oregon provide clear and conclusive regulations which specifically detail where and when a Pilot is required to be aboard vessels. This information should clearly establish offshore boundaries and should also address the use of a Pilot to anchor vessels off the Oregon shoreline. Once published, these regulations should be included in the U.S. Coast Pilot, Number 7.

Action: We concur with this recommendation. A copy of this report will be provided to the Oregon Board of Maritime Pilots for appropriate action.

Recommendation 5: That civil penalty action may be considered against Captain Benjamin Morgado for negligent operation, in violation of 46 United States Code 2302.

Recommendation 6: That civil penalty action may be considered against Chief Officer Angilito Tumalak for negligent operation, in violation of 46 United States Code 2302.

Recommendation 7: That civil penalty action may be considered against Third Officer Patriotico Vigallia for negligent operation, violation of 46 United States Code 2302.

Action: We concur with the Commander, Thirteenth Coast Guard District's disposition of recommendations 5 through 7.

Recommendation 8: That the Republic of Panama and the Republic of the Philippines be provided a copy of this report with a recommendation they examine the proficiency and competency of Captain Morgado, Chief Officer Tumulak, and Third Officer Viguilla.

Action: We concur with this recommendation. Commandant (G-MOA) will forward a copy of this report to the Republic of Panama and the Republic of the Philippines for appropriate action.

Recommendation 9: It is recommended this casualty investigation be closed. There is no need to have a Marine Board of Investigation conduct any further inquiry into this matter.

Action: We concur with this recommendation. This investigation is closed.

T. H. GILMOUR
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Marine Safety and
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